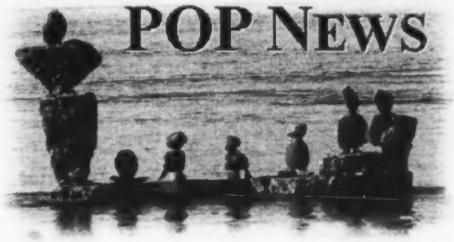

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Message from the Scientific Director

My first few months on the job have been exciting and energizing. I've met with a number of researchers and decision-makers across the country. They have reinforced the magnitude of John Frank's influence on the public and population health scene in Canada and abroad. He made a lasting contribution to our country. Many have also noted the exceptional contributions of our IPPH staff in supporting this work. I've now experienced their talent and commitment first hand and want to thank them for easing me into my role as Scientific Director. Our staff are truly the backbone and life force of the Institute. A special thanks to two members of our team who are moving on to new challenges. Vera Ndaba (who has been with IPPH since 2001) and Fiona Webster (who joined in October 2007) have made many contributions to the successes of IPPH. We will miss you and we wish you well.

Let me take this opportunity to introduce our "new" team. I am very pleased that Erica Di Ruggiero will be continuing as Associate Director for IPPH. She will be working three days a week so that she can devote more time to the next phase of her PhD studies at the University of Toronto. I look forward to working with Kim Gaudreau, Associate, Strategic Initiatives, who is based at CIHR in Ottawa. She continues to provide excellent support for our Institute's strategic initiatives as well as our evaluation and analysis activities. We also have two new team members. I'm delighted to announce that Julie Senecal has taken on the role of Assistant Director (Ottawa-based Institute staff (OBIS)) and Isabelle Legault has joined us as the Administrative Coordinator. Julie has a master's in clinical epidemiology and brings pertinent experience from her work with the clinical research initiative at CIHR. She has recently returned to CIHR following maternity leave. Isabelle has an undergraduate degree in sociology and has worked with the Northern Medical School and Health Canada.

As we turn to the future, it is time to take stock of where we are at, and to consider how we build on the foundations already laid for IPPH. The landscape for public and population health research has changed substantially during the past eight years. With a strong network of public health chairs and research centres, National Collaborating Centres supported by the Public Health Agency of Canada, and many new public health graduate programs, the lay of the land has changed considerably. Yet, vexing inequalities in health status persist as we were reminded by this summer's reports from the Chief Public Health Officer of Canada and the WHO Commission on Social Determinants of Health.

We will be embarking on a strategic planning exercise over the coming months. We will be setting up venues for your input and I look forward to communicating these to you following my first meeting with the Institute Advisory Board in October. I am very grateful for the opportunity to take on this new role and look forward to working and learning with all of you as we tackle the challenges that lay ahead.

Dr. Nancy Edwards,
Scientific Director

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Going Upstream Instead of Downstream:

Finding Health Outside the Health Sector

An article written by the Hon. Monique Bégin, Member of the Commission on Social Determinants of Health and former Canadian Minister of National Health and Welfare

On August 28, the WHO Commission on Social Determinants of Health report was released in Geneva by its Chair, Sir Michael Marmot.

The question now is to find ways to generate action and make sure the report does not remain just that: a good report. It is also about taking ownership of the report and recommendations domestically, for Canadians.

Poverty is almost invisible in today's Canada except for the plight of First Nations and Inuits living conditions and deplorable health indicators. Inner city neighbourhoods have been gentrified or marginalized. Homelessness is being normalized. So are food banks. We may at times find life in the global village a bit challenging but in general, we are very proud of our «Multiculturalism» and believe that there is not much social exclusion in our country. We are really a pretty good country to live in. Both true and not true.

The problem is that Canadians believe they are a very egalitarian society, a classless society. We also think we have as great a safety net as we have a great health care system. We should stop comparing ourselves only to our neighbour to the south. If we are among the biggest spenders of industrialized countries on health care, we have a shameful record when it comes to investing in the security people need when life becomes too difficult. We are very far from the European Nordic countries, among the world's leading nations in terms of both economic and social performance.

In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health and the shortest the life expectancy. In Canada, for 25 years, there is a growing inequality at the bottom. And we should be concerned by it, whether for compassion or self-interest. What does this mean in terms of action?

The Commission recommends three principles of action, which are also its three overarching recommendations :

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.

2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – at all levels.

3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

We are very lucky in Canada to have had the IPPH since 2000, a research locus with a lot of stewardship and leadership in the investigation of social determinants of health in synergy with CPHI and PHAC among others.

I hear all the time that policy interventions research is something missing. Not being an expert, I cannot comment. I know, however, as a « generalist » in health matters and public policy that the various research projects I read about, excellent as they may be, leave me with an acute sense of fragmentation. « These results have been demonstrated in that city, or part thereof. » This is not good enough for governments to move. By fear, bad faith possibly, competing demands on limited resources, a need for certainty in the uncertain (economic and political) times we live in, for whatever exact reason, government policy-makers will not be satisfied with a fragmented view of problems. We have to connect the dots.

Another challenge has to do with learning how to frame the issues, « framing » as in cognitive science. So when McIntyre and Tarasuk, concluded a text by saying : *However, the evidence that we have about food insecurity in Canada has lamentably been neither necessary nor sufficient to galvanize support for the policy changes needed to address this issue*, I want to add something. We should look at the knowledge we want to disseminate in strategic terms, framing the evidence in a way and with words that express our values, to be easily received and accepted.

Research has never been neutral and will never be.

Wicked Problems in Population and Public Health

An article written by Jason Scott Robert, PhD
IPPH Advisory Board Member

Understanding the determinants of health of individuals and populations is a terrifically complex undertaking. We sometimes fool ourselves into believing that new technologies will resolve difficulties in measuring health status and health outcomes, and in intervening to alleviate disease and remediate health inequities. But the challenges of measurement and intervention are not merely technical challenges, and neither do they readily submit to technical or technological solutions. Certainly, technologies may help to generate data and to parse those data. But what data to collect – *what to measure?* — and what to do with those data – *how to intervene?* – are not decided by scientists or technologists alone. These are extrascientific, extratechnological problems. They are, in essence, questions of planning and policy that are, by their very nature, wicked problems.

Thirty-five years ago, Horst Rittel and Melvin Webber published an influential article with an innocuous – indeed, a dull – title: "Problems in a general theory of planning" (Rittel and Webber 1973). Though their underlying philosophy of science is now somewhat dated, Rittel and Webber's analysis remains largely relevant. This is because we as a society have not overcome the scientism that suggests that the answers to our problems of social policy are to be found in science, and the technological fetishism that seeks quick techno-fixes to all our social woes.

But policy problems are not scientific problems. They are planning problems. And while science can and should *inform* the planning process, science cannot *resolve* problems of planning (see Sarewitz 2004 in regard to climate change). Rittel and Webber (1973: 155) summarize what they mean in describing planning problems as inherently 'wicked':

> *Policy problems cannot be definitively described. Moreover, in a pluralistic society there is nothing like the undisputable public good, there is no objective definition of equity, policies that respond to social problems cannot be meaningfully correct or false, and it makes no sense to talk about 'optimal solutions' to social problems unless severe qualifications are imposed first. Even worse, there are no 'solutions' in the sense of definitive and objective answers.*

In other words, neither the policy questions nor the answers are forced on us by nature. The success of a policy choice (and even the identification of a policy gap) will always require the cultivation of political will, the construction and maintenance of good processes, and the negotiation of appropriate goals and outcomes. Science and technology can help – see, for instance, Rychetnik *et al.* (2004) on the role of science in evidence-based policy. But there is no 'pipeline' from science and technology to good public policy. And we never should have expected there would be. And, moreover, there should not be.

I do not mean to sound down on science and technology. Indeed, believe it or not, I'm a big fan! But why anyone should believe that generating vaccines in transgenic plants – a remarkable technical achievement – will *all by itself* solve global public health problems and resolve gross health inequities within and between nations is, quite simply, beyond me (Robert and Kirk 2006). So, too, with personalized medicine as a tool of public health (Campos-Outcalt 2008) and toxicogenomics as a guide to environmental health and safety policy (Smith and Robert 2008).

Against this backdrop, how should we interpret the recently released report of the World Health Organization's Commission on Social Determinants of Health? In *Closing the Gap in a Generation*, the Commission explores how policy action on unemployment, workplace health and safety, urban planning, and health system reform are the keys to health equity in the 21st century. The emphasis is on social justice, and on the processes by which we choose to organize our societies, locally and globally, impacts dramatically on health outcomes. The Commission articulates a moral imperative to achieve health equity, or at least to reduce those avoidable determinants of illness that generate vast health inequities in life expectancy and the personal and societal burdens of disease. *Closing the Gap* is an evidence-based report, though the evidence is not limited to bioscience and biotechnology. The report yields key recommendations to help close the gap. Will we act on them? Will *Closing the Gap* make a difference?

As Rychetnik et al. observe of public health action, "The process of achieving influence is often more difficult, and requires more complex social and political negotiations, than appraising evidence and formulating recommendations" (2004:541). What we do with the Commission's report, and the evidence evaluated therein, depends critically on whether we feel the moral imperative and choose to act politically. Our political choices will affect scientific research and technological developments, hopefully in line with what we know of the social determinants of health. Note that more data and new technologies will not, on their own, close the gap. This is why the biotechnology-rich efforts of well-meaning philanthropists will only ever, at best, be a small part of the solution. Closing the gap is a wicked problem demanding bold and daring political negotiation and policy-making, embedded in and emerging from a rich civil discussion of our moral obligations at home and abroad. Cultivating that discussion is itself wickedly difficult, especially in a pluralistic society, however democratically inclined. That is the critical challenge, the one to which we must turn our collective attention. Else we wind up with a warehouse stuffed to the brim with plant-made vaccines – and no way and no will to deliver them to those in need. And, just as likely, with even greater inequities in health outcomes right here at home.

(Continued on page 3)

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Canadian Public Health Association 2009 Annual Conference
Public Health in Canada: Strengthening Connections

Winnipeg, Manitoba
7-10 June 2009

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Canadian Institutes of Health Research – Institute of Population and Public Health

Public Health Agency of Canada

In association with the:

National Collaborating Centres for Public Health

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The Conference Steering Committee invites submissions for oral and poster presentations.
Information concerning registration and accommodation will be available in December 2008.

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The ICS Program is designed to foster community development by providing grants and awards to individuals and organizations for the purposes of:

- Aiding research and knowledge translation activities where the circumstances fall outside CIHR's programs.
- Supporting organizations and activities whose goals are consistent with the Institute's and CIHR's vision, mandate and strategic directions.

The ICS Program is not intended to support the direct cost of research (e.g., pilot projects, feasibility studies or operating grants), principal and co-investigator salaries or research equipment.

Priority Theme Areas

- Population health intervention research and its use
- Understanding and Promoting Equity in Health

For more information on this program or other IPPH funding opportunities, please visit the CIHR website at: http://www.cihr-irsc.gc.ca/e/13777.html

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For more information, see: http://www.cihr.ca/e/37885.html